Primary care

Project: London—supporting vulnerable populations

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This month the medical humanitarian organisation Médecins du Monde UK launches Project: London, an initiative to help vulnerable migrants, homeless people, and female sex workers to access health care. The founders of the initiative explain why this is needed

Providing health care to marginalised groups is an integral part of Médecins du Monde's work in developed and developing countries. This has been made possible over the past 25 years through the voluntary commitment of health professionals. Médecins du Monde began to provide health care to vulnerable people in Europe 20 years ago in France, when some of the doctors and nurses returning from volunteering overseas realised that people in their own country had no access to health care. The Médecins du Monde European network now runs healthcare projects in Belgium, France, Greece, Italy, Netherlands, Portugal, Spain, and Sweden.

What Project: London will do

Project: London will help people to access health care through its teams of trained volunteers, who will provide people with information, advice, and practical support to access mainstream health services. By working with, and in the premises of, three partner organisations, we are targeting vulnerable migrants, homeless people, and female street sex workers. Priority will be given to people not registered with a general practitioner or who have been denied access to health care. Specially trained support workers will inform people about how to access and use mainstream services, providing information in the service user's own language if necessary. They will help people to register with a general practitioner and to access specialist services such as dental care or counselling. The volunteers will also advocate on behalf of service users if they struggle to access services by making phone calls, organising interpreting services, or accompanying people to their appointments. People coming to Project: London will be able to discuss their health concerns with a fully qualified doctor or nurse. Those in need of short term medical care will be able to receive some treatment until they can access mainstream services. The clinic can offer one-off treatment for most infections and acute conditions. But Project: London is not a general practice and does not offer treatment for long term conditions that need regular monitoring, nor will it prescribe for any condition that requires regular medication or issue repeat prescriptions. Doctors are able to issue private prescriptions from a limited list of drugs, and these prescriptions are available free of charge to service users through our partnership with the retail chain Alliance Pharmacy. Médecins du Monde UK (also known as Doctors of the World UK) is registered with the Healthcare Commission as an independent healthcare provider.

Project: London sessions will take place on the premises of three partner organisations: Praxis, Providence Row, and U-Turn. They have the expertise to provide support in areas other than health (such as housing, basic necessities, legal advice) for their identified populations. Praxis is an organisation committed to advancing the human rights and social justice of displaced people, Providence Row works with homeless people, and U-Turn works with vulnerable women, including women involved in prostitution.

ANDREW AITCHISON

Dr Michael Gerum checks a Nigerian man's leg that has received surgery eleswhere to repair a fracture

Origins of Project: London

From the outset, the Project: London team will collect data about the obstacles to accessing health care and the health needs of its service users. But Médecins du Monde UK is launching Project: London in response to the findings of a needs assessment carried out between June 2003 and April 2004. We wanted to identify whether there are people in the United Kingdom who have difficulty accessing health care, why they don't have access, and what can be done.

Having reviewed the general context and relevant literature, we contacted community organisations working on health issues or working with vulnerable groups, especially in East London. We interviewed

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BMJ 2006;332:115–7

37 organisations to find out about their work and their service users and to seek their views on who has difficulty accessing health care and why. We conducted a series of direct focus group discussions with the clients of organisations, did face-to-face interviews with homeless users of a day centre, and accompanied outreach sessions to do face-to-face interviews with street sex workers. All this confirmed that the most marginalised people had greater difficulties accessing health care. As "being unable to register with a GP" was said to be one of the main obstacles, we conducted a snapshot, anonymous survey of general practices in two London boroughs—Tower Hamlets and Kensington—to identify the extent to which lists were closed to new patients. Later in the needs assessment, we surveyed Praxis's service users to explore issues around access to health care and to assess the level of support for the services proposed by Project: London.

We consulted local health professionals about the scope of existing health services and how we could connect vulnerable people to them without overlapping with existing services. This process of consultation gave us the chance to meet and begin to work with the local primary care trust in Tower Hamlets.

The health situation in London

The initial findings of the needs assessment confirmed social inequalities in access to health care between wealthier and poorer groups, which have widened since the 1970s.[1] Recent data from the Department of Health confirm that the gap continues to widen.[2]

These inequalities mean poorer health, reduced quality of life, and early death for many people. Within London these inequalities are pronounced: life expectancy at birth in the London boroughs of Tower Hamlets and Newham was more than one year less than the average life expectancy for men and women in England between 2001 and 2003.[3] Both Tower Hamlets and Hackney have higher infant mortality rates than England as a whole, and tuberculosis rates are five times the national average.

The discrepancy with the health situation of marginalised groups is even greater. Rough sleepers aged between 45 and 64, for example, have a death rate 25 times that of the general population.[4] Given the poor levels of health in East London, and the fact that our office is based in Tower Hamlets, we concentrated our needs assessment in this area.

East London has high levels of deprivation: in 2004, Tower Hamlets and Hackney were two of the most deprived boroughs in England.[5] About 75% of children in Tower Hamlets live in low income families. The population in these boroughs is ethnically diverse—over half (58%) of people in Tower Hamlets are from ethnic groups other than white British.[6]

Crisis in primary care

At the time of our needs assessment there was widespread concern that primary care services were in crisis, mainly due to the lack of GPs and the fact that many general practices in London were not registering any new patients.[7] Our survey of general practices in Tower Hamlets in 2003 found that 65% of practices declared that their lists were closed to new patients. Concerns were also expressed about the length of waiting times to have an appointment with a GP—one in five people surveyed by Consumers' Association had to wait at least five days to see a doctor.[8]

The Department of Health introduced a programme of action for tackling health inequalities in 2003.[1] The NHS Plan, published in 2000, included targets to increase the number of GPs and to increase the number of patients able to see a GP within 48 hours.[9] Many NHS initiatives at the local level within East London sought to address social inequalities, the difficulties in registering with a GP, and waiting times for appointments. We needed to find out how a humanitarian organisation like ours could support this effort, giving a voice to those who cannot access health care.

Problems accessing health care

People with chaotic lifestyles, such as those living on the streets or working in the sex industry, have difficulty fitting in with the way mainstream health services are organised. They face administrative barriers, such as the need for an address (even if they are homeless), or the need to call the practice at a certain time to get an appointment with a GP. Because their own health is not their priority, and because they have very low self esteem, these people need outreach services who go to them, rather than requiring them to turn up at a given time. Specialist services—such as sexual health services, mental health services, and services for drug users—are well adapted to working in this way, but this approach is much less common for general medical care.

Another group that has trouble accessing health care is migrants, and people who are perceived to be migrants. The lack of information or understanding about how the NHS works is a recurrent problem for them. People who have not grown up with the NHS do not easily understand how to enter it or how to use the health system; others need information in their own language.

The introduction of tougher restrictions on entitlement to NHS care in April 2004[10] and proposals to introduce similar entitlement restrictions on access to primary care[11]—which is currently at the GP's discretion—introduced another barrier to health care for migrants. Before April 2004, anyone who had lived in the UK for at least 12 months, whatever their immigration status, was entitled to both primary and secondary NHS care. Now, most hospital care is available only to those who can demonstrate that they are lawfully resident in the UK. The exceptions are treatment in an accident and emergency department and treatment for some infectious diseases (not HIV) and serious mental illness, which remain free of charge for all.

These restrictions, labelled as "charges for overseas visitors," affect people already living here, such as failed asylum seekers, visa overstayers, and anyone with uncertain immigration status. There is no safety net to ensure that children, pregnant women, or those without resources to pay for private care can have access to health care. Such safety nets exist—for example, in the Netherlands a special fund finances the

Summary points

Some people in the UK find it difficult to access health care

People with chaotic lifestyles, such as those living on the streets, have difficulty fitting in with the way mainstream health services are organised

People who have not grown up with the NHS do not easily understand how to enter it or how to use the health system

Tougher restrictions on entitlement to NHS care introduced in April 2004 are another barrier to health care for migrants

Project: London will help people to access the services that they are entitled to and will speak out for vulnerable people who are unable to access the medical care they need

health care of undocumented migrants, and Belgium, France, and Spain have special state health insurance.

Healthcare professionals report that widespread confusion about these rules means that people who are fully entitled to all NHS care—refugees, asylum seekers, and ethnic minorities—are being wrongly denied access to primary and secondary care. Doctors' professional organisations, such as the British Medical Association and the Medical Practitioners Union, have expressed concerns that it is not the role of doctors to police eligibility for NHS care.[12 13]

Project: London will help people to access the services that they are entitled to. Another key challenge will be to speak out about the fact that there are vulnerable people living in the UK who are being denied access to health care through the new entitlement rules. One of our roles will be to highlight their situation and to work with other concerned organisations to advocate for their right to access the medical care that they need.

Project: London can take place thanks to the kind support of Tower Hamlets Primary Care Trust/Neighbourhood Renewal Fund, Alliance Pharmacy, Clifford Chance, and private donors. Médecins du Monde UK is grateful for this support.

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Competing interests: None declared.

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A memorable patient

Her final days

She was 80 years old when she had come to a provincial town in New Zealand's South Island to end her days in the company of her married son and his family. She had moved from her home in the upper North Island after the diagnosis of her "inoperable carcinoma of the pelvic colon." By the time she had arrived at her destination, she had acute obstruction. The son's family doctor suggested an urgent admission and consultation with myself. The patient had a large mass in the pelvis and was very thin but mentally alert and "with it." We performed a transverse colostomy to relieve the obstruction.

The old woman settled after a few days' anxiety about her condition. She was very keen for something further to be done, and her family agreed. Six weeks after her admission, I therefore proceeded to do a resection and an end to end anastomosis. Admittedly, the cancerous mass was large, but there was no evidence of local spread or liver secondaries. The convalescence was reasonably straightforward. A month later, the colostomy was closed.

Twenty years later, my wife and I were invited to my patient's 100th birthday party—a large gathering of family and friends, almost like a wedding reception. One guest even told my wife how she had said goodbye "forever" to her old friend when she left for the South Island on that trip 20 years before. Instead, she was still keeping house for her bachelor farmer son back in the North Island and acting as a Country Library Service agent. I kept in touch with the family: my former patient was in a rest home for the last year or two of her life. She lived to 107.

If we learn anything from the above, I would say "never let a patient's age be the main arbiter in your decision making."

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